North West **LHIN**

Transforming Our Health System: Together We Can

2008 – 2009 Annual Report

Ontario
Local Health Integration Network

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Our LHIN, Our People

The North West Local Health Integration Network (LHIN) is responsible for planning, integrating and funding many local health services in Northwestern Ontario including hospitals, the Community Care Access Centre, community health centres, long-term care homes, community support service agencies and community mental health and addiction services.

The North West LHIN covers 47% of Ontario's total land mass and is home to 235,046 people (2006), or just 2% of Ontario's population. Our population density of 0.5 people per square kilometre is the lowest in the province.

Our boundaries extend from just west of White River to the Manitoba border and from Hudson Bay in the north to the United States border. Portions of our population live in remote areas (the majority of whom are Aboriginal[1]) with road access only in the winter; others are accessible only by air year-round.

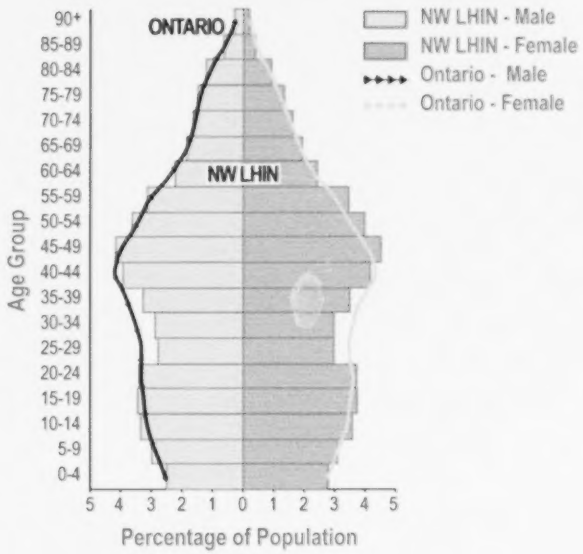
Our communities are spread across 458,000 square kilometres which makes planning, delivering and accessing health services within the northwest challenging. However, the relationships and innovation in our region create opportunities. Together with our partners, the North West LHIN will make the most of every opportunity as it works toward its vision: *Healthier people, a strong health system – our future.*

[1] Including First Nations, Métis and Inuit.

Our Population

- Between 2001 and 2006, the population of the Northwest declined by 1.2%; the population of Ontario increased by 6.6% during this time.
- The percentage of those aged 10 to 19 exceeds the provincial average. However, the smaller percentage of 25 to 39 year olds in the northwest relative to the province suggests young adult out-migration.
- 19.8% of those in the northwest identify as Aboriginal[2]. This is the highest of the 14 LHINs and much higher than the provincial average of 2.0%.
- The proportion of residents who are Francophone is similar to the province as a whole (4.1% versus 4.7%).
- The northwest is in the lowest quartile (at 64.9%) in Ontario for percentage of population in the labour force.
- We have a higher proportion of residents with lower academic achievement compared to the province: more people with less than a grade 9 education (10.6% vs. 8.7%), more without a high school graduation certificate (32.0% vs. 25.7%) and fewer having completed post-secondary education (43.9% vs. 48.7%).

Comparison of North West LHIN and Ontario Population Distribution



- Daily smoking and heavy drinking rates are significantly higher in the North West LHIN relative to the province, as is the prevalence of being overweight/obese. These risk factors help explain our higher burden of disease.

Health Population Profile

- Fewer of our residents report their health as "excellent" or "very good" (51.0%) compared the province as a whole (57.4%).
- A significant proportion of residents (37.5%, compared to 29.4% provincially) report their activities are limited because of a physical or mental condition or health problem which has lasted or is expected to last longer than six months.
- Life expectancy among males and females in the northwest is the lowest in the province.
- In 2001 the age standardized rate of deaths due to suicide for Northwest residents was more than double the provincial average and much higher than in any other region.
- Northwest residents report higher than average rates of chronic diseases, including diabetes, heart disease, high blood pressure, arthritis/rheumatism and asthma.

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[2] Population estimates are based on Statistics Canada 2006 Census data and may under-represent the First Nations population.

Aboriginal Health

- Life expectancy at birth for the Registered Indian population was estimated to be 7.4 years less for males and 5.2 years less for females compared to the overall Canadian population's life expectancies.
- In First Nations, potential years of life lost from injury was more than all other causes of death combined and was almost 3.5 times that of the Canadian rate.
- While First Nations people are hospitalized at a higher rate for most conditions when compared to the Canadian population, the hospitalization for respiratory diseases, digestive diseases, and injuries and poisonings are approximately two to three times higher than Canadian rates.
- The age-standardized prevalence of diabetes among Aboriginals is at least three times that of the general population.

Number of Health Care Facilities and Programs Funded by the North West LHIN

• Community Care Access Centre	1
• Community Health Centres	2
• Community Mental Health and Addictions Services	51
• Community Support Services	82
• Long-Term Care Homes	14
• Hospitals	13
Total	**163**[3]

[3] The North West LHIN provides funding to 104 health service providers, some of which are funded for more than one program.

Message from the Chair and CEO

Janice D.A. Beazley
Chair

Gwen DuBois-Wing
Chief Executive Officer

As Chair and CEO of the North West Local Health Integration Network (LHIN), we continue to build partnerships and relationships with individuals, groups and communities from across the northwest.

Our community engagement activities and participation doubled in 2008/09. We engaged 5,435 individuals at 331 LHIN activities held in the region. There has been much to talk about with our residents, health service providers and other stakeholders including diabetes care, Aging at Home Strategy initiatives, meeting the health needs of Aboriginal people, and advancing the LHIN's priorities for health care change. To support our planning activities and resource allocation, the North West LHIN launched *Share Your Story, Shape Your Care*, an engagement initiative involving a customized interactive website, in January. The information collected through this project, and other engagement activities, will be used to inform the North West LHIN's second Integrated Health Services Plan for 2010 – 2013 which is to be released late in 2009. As well, our Board of Directors has launched a Board-to-Board engagement strategy called *Governing and Leading Our Health System Together*.

The North West LHIN continues to align with the priorities of the Ministry of Health and Long-Term Care, including diabetes and chronic disease prevention and management; e-Health; and emergency department utilization and alternate level of care.

Chronic Disease self management capacity has grown in the North West LHIN. We now have 75 Master Trainers providing self management sessions for clients with chronic diseases throughout the region. As one of five LHINs invited to be an early adopter of the province's Diabetes Strategy, we are engaging various stakeholders and collecting research in order to provide recommendations for advancing the Ontario Diabetes Strategy in the North West LHIN.

We are also working with the Ministry of Health and Long-Term Care to pilot the electronic Diabetes Registry, which is part of the Diabetes Strategy. We are getting ready to participate in the many eHealth projects that will be taking place as the system prepares for electronic health records. The Ministry's goal is for all Ontarians to have an electronic health record by 2015.

In 2008/09 the province announced an Emergency Department/Alternate Level of Care (ALC) Strategy, with the goals of reducing emergency rooms visits for non-urgent care and helping those who are hospitalized to move to an appropriate care setting when they are ready for discharge. To support the ED/ALC Strategy in the Northwest, the North West LHIN has invested $1.3-million in new and enhanced initiatives.

The North West LHIN has negotiated budgets and Accountability Agreements with both the hospitals and multi-sectoral providers, including community support service agencies, mental health and addiction agencies, the community care access centre and community health centres. We have signed Accountability Agreements with our 13 hospitals. We will be negotiating with the Long-Term Care sector in 2009/10.

We continue to be grateful for the support and cooperation we have received from members of our advisory teams and working groups, communities, health service providers and individuals from across the northwest. Your knowledge, experience and enthusiasm have been vital in helping to design a health system that works best for people across Northwestern Ontario.

Janice D.A. Beazley, CHE
Chair

Gwen DuBois-Wing
Chief Executive Officer

Our Board of Directors

The North West LHIN is governed by an appointed Board of Directors and has an Accountability Agreement with the Ministry of Health and Long-Term Care. Board members possess relevant expertise, experience, leadership skills, and have an understanding of local health issues, needs and priorities.

The Board of Directors is accountable, through the Chair, to the Minister of Health and Long-Term Care for the LHIN's use of public funds, and for its results in terms of goals and performance of the local health system. Directors are appointed by Order-in-Council for a term of one to three years, subject to a six-year maximum.

As of March 31, 2009, the North West LHIN has 7 of its 9 members.

Mission, Vision and Values

The Mission, Vision and Values for the North West LHIN provide direction and guide our activities.

Our Mission

Develop an innovative, sustainable and efficient health system in service to the health and wellness of the people of the North West LHIN.

Our Vision:

Healthier people, a strong health system – our future.

Our Values:

1. Person-Centred
2. Culturally Sensitive
3. Sustainable
4. Accountable
5. Collaborative
6. Innovative

Members of the Board

Janice Beazley, *Chair*
Fort Frances

Term: June 1, 2005 to
May 31, 2008
Reappointed to
August 20, 2011

Bob Gregor, *Vice Chair*
Marathon

Term: May 17, 2006 to
May 16, 2008
Reappointed to
May 16, 2011

Ennis Fiddler, *Secretary*
Sandy Lake

Term: June 1, 2005 to
May 31, 2008
Reappointed to
June 15, 2011

Kevin Bähm
Terrace Bay

Term: January 5, 2006 to
January 4, 2008
Reappointed to
January 30, 2011

Marleen Wong
Kenora

Term: January 5, 2006 to
January 4, 2008
Reappointed to
January 4, 2011
Resigned April 23, 2009

Judy Morrison
Fort Frances

Term: May 17, 2006 to
June 16, 2007
Reappointed to
June 16, 2010

Thomas (Tom) Sarvas
Thunder Bay

Term: April 2, 2008
to April 1, 2011

Integrated Health Services Plan

Priorities for Change to the Health Care System in Northwestern Ontario

LHINs bring health care planning closer to home so that local needs can be reflected more easily. They allow for flexible solutions to health needs and enable greater opportunities for continuous and meaningful engagement with the communities they serve and the health service providers that deliver the care.

In order to do all of this, each LHIN created an *Integrated Health Services Plan* (IHSP), a blueprint for the health care needs of their community from 2007–2010.

The North West LHIN's *Integrated Health Services Plan* was developed using the knowledge and input of over 2,500 residents and health service providers, gathered through community engagement activities. The IHSP provides an assessment of local health care needs and existing health services in Northwestern Ontario; identifies broad priorities for health system improvements in our region; and sets out action plans to address these priority health care issues.

The priorities for the Northwest include:

- Access to care
  - *Primary health care*
  - *Chronic disease prevention and management*
  - *Specialty care and diagnostics services*
  - *Mental health and addiction services*
- Long-term care services
- Integration of services along the continuum of care
- Engagement with Aboriginal people
- French language health services
- Integration of e-Health
- Health Human Resources

The IHSPs are being refreshed by the LHINs to ensure their priorities reflect current needs of their residents and service providers. The LHINs' 2010 – 2013 IHSP is to be released in late 2009.

Our Progress

Advancing the North West LHIN's Priorities

We have been carrying out our IHSP in concert with our health service providers and communities – which are essential partners in improving the health care system for our residents. Advisory teams, with citizen and service provider representatives, were created to advise the North West LHIN on many of the priorities in the plan: Chronic Disease Prevention and Management; Health Human Resources; eHealth; Seniors' Services; Mental Health and Addictions, Emergency Department services and System Integration.

Here are highlights as to how the IHSP progressed in 2008/09 in each of the priority areas:

Access to Primary Health Care

Affecting the entire health care system, access to primary care is a priority for the LHIN and was ranked as the most important priority through the *Share your Story, Shape your Care* engagement initiative. Inability to access a regular primary care provider results in high rates of walk-in clinic use, visits to the emergency department for non-emergent reasons and challenges with chronic disease management.

We continue to engage primary care providers working in various settings across the North West LHIN including clinics, community health centres, aboriginal health access centres and family health teams. We will also engage those working at the nurse practitioner clinic and in the nurse led outreach team for long-term care (both in Thunder Bay) when they are established.

In partnership with the family health teams, the LHIN co-hosted *Interprofessional Teams in Primary Care: An Opportunity to Improve Chronic Disease Prevention and Management.*

Chronic Disease Prevention and Management (CDPM)

North West LHIN residents report higher than average rates of chronic disease, making support for chronic disease prevention and management very important. Much attention has been given to building capacity in our region to support individuals to manage their chronic disease. Effective self management improves their quality of life, and there are fewer admissions to hospital as a result.

We hosted several well attended presentations in the region to enhance self management capacity amongst health service providers. In addition, two Stanford University Master Trainer Self Management programs were sponsored by the North West LHIN with a focus on diabetes and chronic diseases. There are now 75 Master Trainers holding self management sessions for clients with chronic diseases throughout the region. A North West LHIN network of Master Trainers has evolved to support this important self management work, which has been generating many patient and service provider success stories.

The North West LHIN was chosen by the Ministry of Health and Long-Term Care to be an early adopter of the Ontario Diabetes Strategy. To prepare for implementation of this strategy:

- Planning and community engagement took place related to the expansion of diabetes services in the region.
- A Diabetes Strategy Advisory Committee, with members from across the region, was established to provide advice on the planning and implementation of enhanced diabetes services in the North West LHIN.
- A report entitled *Diabetes Care in the North West LHIN: An Environmental Scan* was completed.

We will use this research and community engagement to make recommendations to the Ministry for advancing the Ontario Diabetes Strategy in the North West LHIN in year two.

Access to Specialty Care/Diagnostics

Improving access to specialty services for individuals in the North West LHIN will:

- reduce unnecessary visits to specialists
- reduce wait times to specialists, and
- reduce the barriers to accessing specialists geographically

Some of the specialty services provided to smaller rural and remote communities across our vast geographical region occurs through telehealth. We have funded initiatives to improve access to: Tele-Psychiatry; Tele-Ophthalmology; Moving on after Stroke (a self-management program delivered by telemedicine) and Tele-rehab in one remote First Nation community.

Mobile services provide diagnostic and therapeutic services to residents across the Northwest. Service providers and consumers express high satisfaction with care close to home and have identified the need to expand the eye screening, breast screening and Mobile Unit (NorWest Community Health Centres) services across our region.

The North West LHIN Wait Times Working Group addresses the performance for surgical procedures outlined under the Access to Care Wait Time Strategy.

Mental Health and Addictions

The North West LHIN has developed, with the involvement of its Mental Health and Addictions Advisory Team members and others, a mental health and addictions service matrix. At a glance, the matrix provides the local, district and regional services that are available in each community. The tool will help identify service access challenges and assist future planning.

We funded a three-year pilot project to identify and respond to the unmet needs of a population of vulnerable persons with serious, unstable and complex mental illness and addictions issues. The GAPPS (Getting Appropriate Personal and Professional Supports) program involved a core partnership of three organizations: Canadian Mental Health Association, Thunder Bay; Alpha Court Non-Profit Housing Inc. and St. Joseph's Health Centre. Many other partners have since become involved to provide outreach and engagement services; support and system navigation; and clinical services.

Long-term Care

For the purpose of future planning and budgeting, a Long-Term Care Local Area Plan (LAP) was updated to provide a current analysis of long-term care services supply and demand. The last plan was prepared in 2005-06.

The government announced the creation of a Nurse Led Outreach Team in Thunder Bay in 2009. This team of nurse practitioners and registered nurses will travel to long-term care homes to assess urgent problems, determine the need for hospital care and provide interventions, such as intravenous therapy, antibiotic management and administering oxygen, in cases where unnecessary visits to the hospital and the ER can be avoided.

Hundreds of seniors across the northwest are benefiting from a number of initiatives approved by the North West LHIN Board (see listing next page). New and enhanced programs are offering more community supports to our seniors to allow them to stay in their homes longer and reduce the pressures on our emergency departments and acute care hospital beds. The services, which are in various stages of implementation, cover a broad range of seniors' needs from non-medical supports through to services for seniors with higher health care needs. The initiatives are being funded through the Aging at Home Strategy.

The Centre of Excellence for Integrated Seniors' Services (CEISS), announced in 2007, fits with the province's Aging at Home Strategy. The routine re-building of long-term care beds in Thunder Bay was transformed into a project creating a true continuum of services for seniors with supportive housing, community support services, and long-term care, including behavioural beds for residents from across the LHIN. The CEISS Steering Committee and its four working groups (Community Supports, Communications, Supportive Housing and Behavioural Health Program) continue to meet to advance this project. LHIN staff members sit on this committee.

Also as part of the Aging at Home Strategy, eight vans were allocated to service provider organizations throughout the northwest. The vans are operating in Marathon, Thunder Bay (two vans), Dryden, Fort Frances, Kenora, Sioux Lookout and Geraldton. They provide health-related transportation for seniors within urban areas and for longer distance travel between rural and remote communities.

Seniors' Initiatives in 2008/09

North West LHIN-Wide:

North West LHIN-Wide Falls Prevention Project, *St. Joseph's Care Group*: This region-wide project is bringing together over 30 health care organizations to develop a comprehensive, community based approach to reducing seniors' falls and injuries.

Thunder Bay District:

Family Directed Respite Service for Seniors in the District of Thunder Bay, *Wesway*: Family directed respite care is being provided to caregivers of frail seniors in the District of Thunder Bay.

Programs for Community Living, *Wilson Memorial Hospital, Marathon; McCausland Hospital, Terrace Bay/Schreiber*: A flexible basket of services is being provided to seniors based on their unique needs and enabling them access to multiple services through a single access point.

North Shore MedExpress, *Manitouwadge General Hospital*: A medical transit bus is providing travel between Manitouwadge to specialized services in Thunder Bay.

Kenora District:

Rural Geriatric Primary care Outreach Program, *Mary Berglund Community Health Centre*: A Geriatric Mobile Unit is providing weekly health care services by a nurse practitioner to seniors in Ignace and the outlying communities of Dinorwic and Savant Lake. Homebound seniors receive in-home visits.

City of Thunder Bay:

Smooth Transitions, *Saint Elizabeth Health Care*: Personal Support Workers are escorting seniors from Thunder Bay Regional Health Sciences Centre and ensuring they are safe and comfortable in their own homes.

Seniors Maintaining Active Roles Together (SMART) Program, *Victorian Order of Nurses*: Trained volunteers are providing a progressive model of physical activity to isolated, homebound, sedentary seniors at home as a positive health intervention.

First Link, *Alzheimer Society of Thunder Bay*: First Link is providing referral and early intervention, linking individuals and caregivers to coordinated services and education from the point of diagnosis and through the continuum of the disease.

Enhanced and Expanded Respite Services, *Wesway*: New and enhanced respite care is being provided for caregivers of frail seniors in Thunder Bay.

Expanded Home Help, Maintenance & Repair, and Congregate Dining, *Red Cross*; Seniors are receiving the help they need to stay in their homes, and isolated seniors have companionship at meals.

Expanded Meals on Wheels Service, *City of Thunder Bay*; This service is ensuring more seniors at home are eating well and staying healthy.

Supportive Housing Enhancements, *City of Thunder Bay and St. Joseph's Care Group*; This initiative is providing additional Personal Support Worker time for the seniors living in Jasper Place (City of Thunder Bay) and P.R. Cook (St. Joseph's Care Group) to help them remain in supportive housing rather than having to be moved to long-term care.

Network of Individualized Community Enhancements (NICE) Fund, *North West Community Care Access Centre*; This fund is assisting health service providers in managing time-limited, extraordinary costs that meet the needs of seniors to maintain them in the community.

Aboriginal People:

Principles of Physical Rehabilitation: A Training Workshop for Personal Support Workers in Remote First Nation Communities, *Thunder Bay Regional Health Sciences Centre*: Two workshops are providing the principles and hands-on training related to physical rehabilitation to Personal Support Workers from 15 remote First Nation communities.

eHealth

A new provincial agency, eHealth Ontario, was created to take the lead role in harnessing information technology and innovation to improve patient care, safety and access in support of the government's health strategy. The North West LHIN has advanced a number of regional eHealth initiatives to align the North West with eHealth Ontario's strategic directions.

eHealth capability at the LHIN was enhanced with the creation of an eHealth Advisory Team, further development of the Project Management Office, and the appointment of a full-time Chief Information Officer to carry out the eHealth Lead role.

eHealth capacity in the region was also enhanced. The LHIN and its PMO have contributed to a number of successful regional eHealth projects such as:

- the initiation of an electronic diabetes registry and management tool
- an upgrade to the regional information and communication technology infrastructure
- the implementation of ePhysician initiatives
- the initiation of a patient-resource matching and eReferral project
- the expansion of Drug Profile Viewer at all hospitals in the region
- the creation of new network management services
- the creation of new privacy and security resources
- the development of a Northern Ontario Directory of Health Services
- the expansion of eHealth Ontario ONE Network
- an increase in eHealth engagement and outreach

The North West LHIN is refreshing its eHealth tactical plan to ready itself for involvement in eHealth pilot projects and reap the eHealth benefits earlier for our region.

Integration Along the Continuum

The System Integration Committee provides strategic advice to the North West LHIN senior leadership team. The Committee includes health service providers including CEOs, consumers, academic representatives and North West Board members and staff.

Over the past year the committee provided feedback on the following initiatives:

- Integrated Health Services Plan and priorities;
- Priority Setting and Decision Making Framework;
- Overarching ED/ALC Plan;
- Emergency Department Study;
- Initiatives and priorities of the various Advisory Teams/Committees of the LHIN (e.g. Wait Times Strategy);
- Relevant research findings for studies sponsored by the North West LHIN (e.g. FLO Collaborative);
- Opportunities for system integration

French Language Services

The North West LHIN continues to meet with Francophone organizations and stakeholders. The perspective of the Francophone community is also provided through membership on LHIN Advisory Teams. Our *LHINkages* newsletter keeps Francophone stakeholders abreast of LHIN activities. During 2008/09, we co-hosted a consultation session in Thunder Bay with the Ministry of Health and Long-Term Care and community partners regarding the development of Francophone engagement regulations under the Local Health System Integration Act.

Engagement of Aboriginal People

Two projects are under way to increase our awareness of the scope and types of programs and services available to Aboriginal communities. They are:

- An environmental scan project to conduct a survey of existing Aboriginal health services and programs and the health status of Aboriginal People within the North West LHIN.
- A Mental Health and Addictions project to develop a plan for the delivery of an integrated model of care for individuals living on and off reserve

The information and data collected through these projects will be used in our long range planning. Both projects are to be completed by March 2010.

The *2009 Aboriginal Health Forum, Pathways for Collaboration* was hosted in Thunder Bay in March. Approximately 130 people attended from 36 communities across the North West LHIN. The purpose of the Forum was to continue to build relations with the Aboriginal community, to discuss collaborative opportunities and to share strategies of what was working well in the region. Success stories were presented from the provincial, regional and local levels on four key topic areas; Community Engagement Protocols; Chronic Disease Prevention and Management; Seniors Services; Mental Health and Addictions; and e-Health.

Community engagement is ongoing and information sessions continue to be provided by the LHIN at the request of communities and organizations.

Health Human Resources

Over the past year we have partnered with a number of organizations, including the Northern Ontario School of Medicine (NOSM), Lakehead University, Confederation College, North of Superior Training Board, Northwest Training and Adjustment Board, HealthForceOntario, the Nursing Secretariat, Thunder Bay Medical Society, and health service providers across the region.

The LHIN supported the Health Professions Regulatory Advisory Council (HPRAC) to host sessions in Northwestern Ontario regarding suggested changes to scopes of practice for dieticians, pharmacists, midwives and physiotherapists; co-hosted sessions with NOSM, the Thunder Bay Medical Society and family health teams; co-sponsored *Check-Up: A Guide to Health Careers in Northwestern Ontario*; and collaborated with HealthForceOntario's Community Partnership Program Coordinator for the North West.

By working on these priorities together with our health service providers and partners, we will succeed at improving the quality of and accessibility to health care services for the residents of Northwestern Ontario and achieve the North West LHIN's vision ***Healthier people, a strong health system—our future.***

Community Engagement Activities

Engaging Our Communities

Community engagement provides information that is used when identifying health system priorities, innovations to overcome challenges and opportunities to develop new partnerships and to work together.

In 2008/09, the North West LHIN engaged over 5,435 individuals at 331 sessions across the Northwest including forums, roundtable discussions, meetings, workshops and training, and surveys. Given the interconnectedness of our health system, stakeholders include health service providers; community members and leaders; educators; municipal, provincial and federal government officials; other ministries and jurisdictions; and other funding agencies.

Engagement focused on issues such as advancing the priorities outlined in the North West LHIN's IHSP, Multi-Sectoral Service Accountability Agreements, Aging at Home, diabetes and updates on LHIN activities. The LHIN shares information broadly through our newsletter, *LHINkages*, and website.

We evaluate sessions using evaluation forms and providing opportunities for feedback. To date, the majority of feedback has been very positive. Where there are suggestions for improvement (often environmental), we modify and improve our community engagement activities as we proceed. We are working with Dr. Julia Abelson from McMaster University and the other LHINs to develop evaluation tools for monitoring and reporting the effectiveness of our community engagement activities. To support this work provincially, a session for all LHINs was hosted by the Change Foundation in March; the North West LHIN participated and was represented on the steering committee for this event.

To increase the reach of our engagement, the North West LHIN continues to build on its innovative delivery and collection of information. The LHIN hosts a videoconference speaker series featuring experts in a variety of areas, which are archived on the North West LHIN website. Full presentations from a number of forums and conferences are available online via YouTube, increasing accessibility to those across Northwestern Ontario's vast geography.

The LHIN's largest engagement project in 08/09 was its *Share your Story, Shape your Care* initiative. This project combined the use of an online 'choice book', YouTube video, option for online posting, weekly blog and conversation guide providing an opportunity for residents in the North West LHIN to weigh in on and identify areas for priority and to share their opinions, stories and ideas. During the seven week collection of input, 806 individuals participated. Paper copies of the choice book were collected until April 30, 2009. Information collected through this initiative will help to develop the second *Integrated Health Services Plan* (IHSP).

The North West LHIN hosts a number of Advisory Teams, Committees and Work Groups to advance the priority areas identified in the IHSP. We work with individuals, groups and organizations in and outside of Northwestern Ontario and partner with health service providers in a number of ways, including those who are not funded by the LHIN, such as public health units, the Northern Ontario School of Medicine, Lakehead University, Confederation College, physicians and provincial programs. In December, we hosted our first citizens' panel, *Engaging with Impact: Citizens' Workshop on Engagement and Health* for community members from across the region.

We will continue to engage stakeholders from across the LHIN in planning, priority-setting and decision-making processes and work with partners in other LHINs and jurisdictions to advance health system transformation in the northwest.

Integration Activities

Several voluntary integrations under section 27 of LHSIA were proposed to the LHIN during the year. One integration, aimed at improving the quality of care for patients, involved the expansion of digital Picture Archiving and Communication Systems (PACS) to include hospitals in the North West, North East and Champlain LHINs. This integration enhances the ability to electronically share images across the three LHINs. Additionally, three voluntary integrations involving nine community health service providers were completed during the year. These integrations were undertaken to reduce administrative burden, better align accountability for the providers and to maintain the quality of care in the communities.

Ministry-LHIN Accountability Agreement (MLAA)

The North West Local Health Integration Network (LHIN) and the Ministry of Health and Long-Term Care have negotiated and signed an accountability agreement which defines the obligations and responsibilities of both the LHIN and the Ministry for the period 2007/08 to 2009/10. The agreement includes a number of schedules which outline how the LHIN is to carry out activities related to areas such as Community Engagement, Planning and Integration; Local Health System Management; Financial Management and Local Health System Performance and eHealth.

This type of agreement is mirrored in the Accountability Agreements that LHINs have already negotiated or are in the process of negotiating with health service providers such as hospitals, multi-sectoral agencies and the long term care sector.

Report on MLAA Performance Indicators

Schedule 10 of the Ministry-LHIN Accountability Agreement (MLAA) for 2008/09 sets out performance indicators for the local health system. By setting these targets, the LHIN and Ministry are working towards improving the local health system performance and supporting the achievement of provincial targets.

In 2008/09, the LHIN made great improvements in the wait times for Cataract surgery, reducing the wait at the 90th percentile from 503 days down to 101 days. Wait times for MRI and CT scans were also significantly reduced, with the wait at the 90th percentile going from 64 and 85 days to 38 and 27 days respectively. In the area of cancer surgery, the LHIN continues to be one of the top performers in the province with a wait at the 90th percentile of 46 days. Hip replacement wait times were consistent with the prior year, while knee replacement wait times were reduced by 21 days.

Within the LHIN, many new initiatives were implemented to reduce ALC pressures and improve the flow of patients from acute centers into appropriate settings. These initiatives reduced the level of ALC as evidenced by data received subsequent to the year end showing reductions in both ALC days and the wait times for long-term care placement.

Additional MLAA indicators including the hospitalization rate for ambulatory care sensitive conditions, the rate of emergency department visits that could be managed elsewhere and the readmission rates for acute myocardial infarction are also monitored by the LHIN. Improving the performance for these indicators presents significant challenges due to the rural and remote nature of the LHIN.

The following table outlines indicators measured in the North West LHIN in 2008/09.

Performance Indicator	LHIN 08/09 Starting Point	LHIN 08/09 Target	Most Recent Quarter 2008/09*	Annual Results**	LHIN Met Target Yes/No
1. 90th Percentile Wait Times for Cancer Surgery	47 Days	45 Days	42 Days	46 Days	Yes
2. 90th Percentile Wait Times for Cataract Surgery	503 Days	182 Days	101 Days	103 Days	Yes
3. 90th Percentile Wait Times for Hip Replacement	197 Days	197 Days	200 Days	212 Days	Yes
4. 90th Percentile Wait Times for Knee Replacement	232 Days	214 Days	211 Days	189 Days	Yes
5. 90th Percentile Wait Times for Diagnostic MRI Scan	64 Days	28 Days	38 Days	71 Days	No
6. 90th Percentile Wait Times for Diagnostic CT scan	85 Days	28 Days	27 Days	29 Days	Yes
7. Hospitalization Rate for Ambulatory Care Sensitive Conditions (ACSC)	608.42	600	554.27	594.91	Yes
8. Median Wait to Long-Term Care Home Placement - All Placements	154 Days	135 Days	165 Days	183 Days	No
9. Percentage of Alternate Level of Care Days - by LHIN of Institution	20.40%	14.78%	20.30%	18.81%	No
10. Rate of Emergency Department Visits that could be Managed Elsewhere	69.35	60	65.55	62.56	Yes
11. Readmission Rates for Acute Myocardial Infarction (AMI)	6.50	6.50	6.04	6.34	Yes

Note:

* **Performance indicators 1-7 = Q4 2008/09; and 8-11 = Q3 2008/09**

** **Performance indicators 8-11 (in the Annual Results Column) only include the average of Q1-3**

LHIN Initiatives in Support of Government Priorities

Improving Patient Flow and System Capacity by Addressing Emergency Department Pressures and Alternate Level of Care

One of the greatest health care challenges facing the North West LHIN is the increasing numbers of alternate level of care patients occupying acute care beds. Alternate level of care (ALC) means the patient has completed the acute care phase of treatment and is in a hospital bed when he or she would be better cared for in an alternate setting such as complex continuing care, rehabilitation or long-term care[4]. A contributing factor to the ALC situation is that options in the community are not readily available or do not exist and the patient remains in hospital. This creates a backlog in the emergency department (ED) when the next patient needs to be admitted and no beds are available in the hospital.

From January to March 2008, 20.4% of the acute care beds in the North West LHIN were occupied by ALC patients. Many of the ALC patients were waiting in hospital for long-term care. Similar trends were noted across the province of Ontario. As a result of the increasing pressures within hospitals, the Ministry of Health and Long-Term Care announced ED/ALC as a provincial priority.

The North West LHIN placed a high priority on ED/ALC and developed a detailed ED/ALC Plan that will provide solutions so that patients will receive care at the right time in the right place, and to improve the flow of patients across the continuum of care.

The ED/ALC targets for the North West LHIN in 2009/2010 include:

- Reduce ALC days to 13%;
- Decrease ED wait times for admitted and non-admitted, high and low acuity patients and improve patient satisfaction, and;
- Reduce the time to placement in a LTC setting to 135 days.

Solutions include:

Reducing unnecessary visits to the ED

- Creating more community support services for ALC patients; and
- Implementing best practices in Falls and Wound Management LHIN-wide.

Reducing ED wait times and improving patient satisfaction

- Implementing strategies in the ED to improve the patient flow for both high and lower acuity patients including admitted patients.

Improving bed utilization (faster discharge of ALC Patients).

- Creating additional capacity in the community such as:
    - Transitional care in a retirement home setting in Thunder Bay;
    - Increasing supportive housing capacity in Thunder Bay and across the Northwest region;
    - Increasing community supports services across the North West LHIN;
    - eHealth solutions to match the ALC patient to the first appropriate place in the community;
    - Increasing homemaking services to support frail seniors to live safely at home; and
    - Reducing the reliance on long-term care beds as the only option.

---

[4] The definition of ALC is currently under review.

Alternate level of care is not a new issue. It is a longstanding, complex health system issue that requires partners to work collaboratively to transform the health system so that limited resources can be maximized to help support seniors to stay healthy, safe and independent at home.

North West LHIN Special Initiatives

Regional Emergency Department (ED) Study

Some hospitals in the North West LHIN are experiencing challenges with recruiting and retaining physicians to ensure 24 hour operation of their emergency departments. A few hospitals have had to plan for the possibility of having to close their emergency departments some evenings and weekends. They have had to rely on locums or out-of-town physicians to fill the gaps temporarily. The North West LHIN commissioned a regional ED Study with the purpose of analyzing what needs to be done to ensure that high quality emergency and urgent care is available and sustainable for residents in Northwestern Ontario.

The North West LHIN's Emergency Department Advisory Team supports the need for this study, which will identify:

- Opportunities for creative/innovative use of existing resources;
- Strategies to address HHR that impact ED coverage;
- Strategies to improve system integration and coordination of Emergency Department

Preliminary findings of the study are to be released in May 2009, which will be shared with the ED Advisory Team and stakeholders for feedback before the final report is prepared for the North West LHIN Board for consideration.

Priority Setting / Decision Making Framework

Establishing priorities is an important component of planning. The North West LHIN was one of three LHINs in the province to pilot the use of a decision-making framework designed to help realign resources strategically with system goals and community needs; facilitate constructive community engagement to address system goals within available resources; identify opportunities to improve integration and enhance services; and fulfill its public accountability for health system resources.

The pilot was implemented with guidance from Dr. Craig Mitton, University of British Columbia, and Dr. Jennifer Gibson, University of Toronto. In the North West LHIN, the framework was piloted with the Urgent Priorities Fund, with a call for proposals that advance the Ministry's Emergency Room/Alternate Level of Care Strategy.

In February 2009, we facilitated a workshop for staff and board members of the LHINs across the province to review the priority-setting framework, review the evaluation findings, identify challenges and solutions, and plan for next steps and opportunities for cross-LHIN collaboration.

We have made refinements to the framework and will be using it with future priority-setting initiatives.

Research

The North West LHIN collaborated on a research project with the Centre for Rural and Northern Health Research at Lakehead University to determine the population health impact of the decline in the forestry industry. The report, titled *Forestry and Health: An Exploratory Study of Health Status and Social Well-Being* was released in July 2008. It identifies general trends and, more specifically, communities at risk. The report also provides critical baseline data to support future decision making.

North West LHIN's Operational Performance

During the year, the LHIN continued its recruitment activities, building a strong team in order to deliver on an ambitious agenda. The LHIN hired new staff including a Chief Information Officer and e-Health Lead; a Diabetes Strategy Lead and Community Engagement Coordinator (both contract); Chronic Disease and Prevention Management Project Coordinator (contract); and a Business and Performance Analyst. The total number of staff as at March 31, 2009 was 27.

The North West LHIN operational budget was $5M; we ended the year with a $128,550 surplus.

Financial statements of

North West Local Health Integration Network

March 31, 2009

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Auditors' Report

To the Members of the Board of Directors of the
North West Local Health Integration Network

We have audited the statement of financial position of the North West Local Health Integration Network (the "LHIN") as at March 31, 2009 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the North West Local Health Integration Network as at March 31, 2009 and the results of its operations, its changes in its net debt and its cash flows for the year then ended, in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
April 24, 2009

Member of
Deloitte Touche Tohmatsu

North West Local Health Integration Network

Statement of financial position

as at March 31, 2009

	2009	2008
	$	$
Financial assets		
Cash	**1,470,670**	1,103,450
Due from Ministry of Health and Long Term Care ("MOHLTC") - Health Service Providers ("HSP") transfer payments (Note 9)	**1,579,880**	645,420
Due from HSPs	**-**	107,730
	3,050,550	1,856,600
Liabilities		
Accounts payable and accrued liabilities	**1,020,593**	706,549
Due to HSPs (Note 9)	**1,579,880**	753,150
Due to MOHLTC (Note 3B)	**417,798**	388,136
Due to the LHIN Shared Services Office (Note 4)	**32,279**	8,765
Deferred capital contributions (Note 5)	**169,775**	333,886
	3,220,325	2,190,486
Commitments (Note 6)		
Net debt	**(169,775)**	(333,886)
Non-financial assets		
Capital assets (Note 7)	**169,775**	333,886
Accumulated surplus	**-**	-

Approved by the Board

Director

Director

North West Local Health Integration Network

Statement of financial activities
year ended March 31, 2009

	Budget (unaudited) (Note 8)	2009 Actual	2008 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSPs transfer payments (Note 9)	**536,047,500**	**542,638,165**	519,403,649
Operations of LHIN	**4,859,600**	**4,841,175**	3,912,015
Aboriginal Community Engagement (Note 11)	**160,000**	**160,000**	160,000
E-Health (Note 12)	**120,000**	**600,000**	275,000
Aging at Home Strategy (Note 13)	-	-	158,000
Emergency Department ("ED") Lead (Note 14)	-	**75,000**	37,500
Ontario Wait-Time Strategy (Note 15)	-	-	70,000
Ontario Diabetes Strategy (Note 16)	-	**224,700**	-
Emergency Room/Alternative Level of Care ("ER/ALC") Performance Lead (Note 17)	-	**33,300**	-
70% Full Time Nursing Initiative (Note 18)	-	**42,750**	-
Aboriginal Health Transition (Note 19)	-	**165,625**	-
Amortization of deferred capital contributions (Note 5)	-	**182,536**	176,395
	541,187,100	**548,963,251**	524,192,559
Expenses			
Transfer payments to HSPs (Note 9)	**536,047,500**	**542,638,165**	519,403,649
General and administrative (Note 10)	**4,859,600**	**4,895,161**	3,897,291
Aboriginal Community Engagement (Note 11)	**160,000**	**155,067**	118,442
E-Health (Note 12)	**120,000**	**541,725**	274,740
Aging at Home Strategy (Note 13)	-	-	9,599
ED LHIN Leader (Note 14)	-	**71,651**	30,702
Ontario Wait-Time Strategy (Note 15)	-	-	70,000
Ontario Diabetes Strategy (Note 16)	-	**152,351**	-
70% Full Time Nursing Initiative (Note 18)	-	**36,333**	-
	541,187,100	**548,490,453**	523,804,423
Annual surplus before funding repayable to the MOHLTC	-	**472,798**	388,136
In year surplus recovered by MOHLTC transferred to the LSSO	-	**(55,000)**	-
Funding repayable to the MOHLTC (Note 3B)	-	**(417,798)**	(388,136)
Annual surplus	-	-	-
Opening accumulated surplus	-	-	-
Closing accumulated surplus	-	-	-

North West Local Health Integration Network

Statement of changes in net debt

year ended March 31, 2009

	2009	2008
	$	$
Annual surplus	-	-
Acquisition of capital assets	**(18,425)**	(33,769)
Amortization of capital assets	**182,536**	176,395
Decrease in net debt	**164,111**	142,626
Opening net debt	**(333,886)**	(476,512)
Closing net debt	**(169,775)**	(333,886)

North West Local Health Integration Network

Statement of cash flows

year ended March 31, 2009

	2009	2008
	$	
Operating		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**182,536**	176,395
Amortization of deferred capital contributions (Note 5)	**(182,536)**	(176,395)
	-	-
Changes in non-cash operating items		
Increase in due from MOHLTC - HSPs transfer payments	**(934,460)**	(645,420)
Decrease (increase) in due from HSPs	**107,730**	(107,730)
Increase in accounts payable	**314,044**	376,236
Increase in due to HSPs	**826,730**	753,150
Increase in due to MOHLTC	**29,662**	388,136
Increase (decrease) in due to LHIN Shared Services Office	**23,514**	(62,857)
	367,220	701,515
Capital transactions		
Acquisition of capital assets	**(18,425)**	(33,769)
Financing transactions		
Increase in deferred capital contributions (Note 5)	**18,425**	33,769
Net increase in cash	**367,220**	701,515
Cash, beginning of year	**1,103,450**	401,935
Cash, end of year	**1,470,670**	1,103,450

North West Local Health Integration Network

Notes to the financial statements
March 31, 2009

1. Description of business

The North West Local Health Integration Network was incorporated by Letters Patent on June 16, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the North West Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2009.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the Districts of Thunder Bay, Rainy River and most of Kenora. The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of capital assets and impairments in the value of assets.

2. Significant accounting policies (continued)

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to Health Service Providers ("HSPs"), effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the Ministry of Health and Long Term Care ("MOHLTC") of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN statements do not include any MOHLTC managed programs.

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as capital assets, are recorded as deferred capital contributions and are recognized over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Office furniture and fixtures	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Web development	3 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year.

2. Significant accounting policies (continued)

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

A. The amount repayable to the MOHLTC related to the current year activities is made up of the following components:

	Revenue	**Expenses**	**2009 surplus**	2008 surplus
	$	**$**	**$**	$
Transfer payments to HSPs	**542,638,165**	**542,638,165**	**-**	-
LHIN operations	**5,023,711**	**4,895,161**	**128,550**	191,119
Aboriginal Community Engagement	**160,000**	**155,067**	**4,933**	41,558
Aging at Home	**-**	**-**	**-**	148,401
E-Health	**600,000**	**541,725**	**58,275**	260
Ontario Diabetes Strategy	**224,700**	**152,351**	**72,349**	-
ED LHIN Lead	**75,000**	**71,651**	**3,349**	6,798
70% Full-Time Nursing Initiative	**42,750**	**36,333**	**6,417**	-
ER/ALC Performance Lead	**33,300**	**-**	**33,300**	-
Aboriginal Health Transition	**165,625**	**-**	**165,625**	-
	548,963,251	**548,490,453**	**472,798**	388,136

B. The amount due to the MOHLTC at March 31 is made up as follows:

	2009	2008
	$	$
Due to MOHLTC, beginning of year	**388,136**	-
Funding repaid to MOHLTC	**(388,136)**	-
Funding repayable to the MOHLTC related to current year activities (Note 3A)	**472,798**	388,136
In year surplus recovered by MOHLTC transferred to the LSSO	**(55,000)**	-
Due to MOHLTC, end of year	**417,798**	388,136

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all LHINs.

5. Deferred capital contributions

	2009	2008
	$	$
Balance, beginning of year	**333,886**	476,512
Capital contributions received during the year	**18,425**	33,769
Amortization for the year	**(182,536)**	(176,395)
Balance, end of year	**169,775**	333,886

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due in each of the next three years as follows:

	$
2010	196,554
2011	64,597
2012	18,389
	279,540

The LHIN also has funding commitments to HSPs associated with accountability agreements. Minimum commitments to HSPs related to the next two years, based on the current accountability agreements and are as follows:

	$
2010	410,537,960
2011	30,284,744

The actual amounts which will ultimately be paid are contingent upon LHIN funding received from the MOHLTC.

7. Capital assets

	Cost	Accumulated amortization	2009 Net book value	2008 Net book value
	$	$	$	$
Office furniture and fixtures	**237,865**	**189,514**	**48,351**	95,924
Computer equipment	**86,950**	**65,993**	**20,957**	32,012
Leasehold improvements	**489,420**	**391,536**	**97,884**	195,768
Web development	**24,289**	**21,706**	**2,583**	10,182
	838,524	**668,749**	**169,775**	333,886

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of Financial Activities reflect the initial budget. The figures have been reported for the purposes of these statements to comply with PSAB reporting principles. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $542,638,165 is derived as follows:

	$
Initial budget	**536,047,500**
Adjustment due to announcements made during the year	**6,590,665**
Final budget	**542,638,165**

The final LHIN budget of $6,142,550 is derived as follows:

	$
Initial budget	**5,139,600**
Additional funding received during the year	
E-Health	**480,000**
ED LHIN Lead	**75,000**
Ontario Diabetes Strategy	**224,700**
ER/ALC Performance Lead	**33,300**
70% Full Time Nursing Initiative	**42,750**
Aboriginal Health Transition	**165,625**
Amount treated as capital contributions made during the year	**(18,425)**
Final budget	**6,142,550**

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $542,638,165 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2009 as follows:

	2009	2008
	$	$
Operation of hospitals	**384,672,076**	370,660,496
Grants to compensate for municipal taxation - public hospitals	**104,250**	104,250
Long term care homes	**58,298,833**	53,149,625
Community care access centres	**35,552,976**	33,849,253
Community support services	**11,668,305**	10,569,661
Acquired brain injury	**1,025,159**	1,072,722
Assisted living services in supportive housing	**4,592,325**	4,210,806
Community health centres	**6,606,360**	6,557,455
Community mental health program	**28,764,744**	28,133,615
Addictions program	**11,353,137**	11,095,766
	542,638,165	519,403,649

The LHIN receives money from the MOHLTC which in turns allocates it to the HSPs. As at March 31, 2009, an amount of $1,579,880 (2008 - $107,730) was receivable from the MOHLTC, and $1,579,880 (2008 - $753,150) was payable to the HSPs. These amounts have been reflected as revenue and expenses with the LHIN's financial activities and are included above.

10. General and administrative expenses

The Statement of Financial Activities presents the expenses by function, the following classifies these same expenses by object:

	2009	2008
	$	$
Salaries and benefits	**2,702,197**	2,068,882
Occupancy	**185,952**	192,788
Amortization	**182,536**	176,395
Equipment and maintenance	**63,512**	66,209
Shared services	**300,000**	300,000
Public relations and community forums	**103,501**	49,161
Professional fees	**14,500**	14,000
Staff travel	**284,222**	224,032
Staff development and recruitment	**165,032**	189,815
Consulting services	**442,054**	219,049
Supplies, printing and office	**99,802**	95,828
Board member per diems	**112,390**	121,775
Board member expenses	**133,123**	105,823
Mail, courier and telecommunications	**106,340**	73,534
	4,895,161	3,897,291

11. Aboriginal Community Engagement

The Ministry of Health and Long-Term Care provided $160,000 (2008 - $160,000) in additional base operational funding which was annualized for the purposes of engaging the Aboriginal population and organizations in the North West LHIN. During 2009, $155,067 (2008 - $118,442) of expenses were incurred

12. E-Health

The E-Health office of the Ministry of Health and Long-Term Care provided $600,000 to the LHIN (2008 - $275,000). The LHIN had a contract and retained the services of the Group Health Centre (the "GHC") during 2008 and 2009. The GHC provides services and deliverables as described in the contract. In return, the LHIN agreed to reimburse the GHC for expenses incurred during the performance of this work. During the year, $541,725 (2008 - $274,740) of expenses were incurred.

13. Aging at Home Strategy

The Ministry of Health and Long-Term Care provided $158,000 in funding in 2008 to assist with implementation planning for the Aging at Home Strategy. This funding was discontinued for 2009 and there were no expenses incurred in the current year (2008 - $9,599).

14. Emergency Department LHIN Lead

The ED LHIN Lead Agreement originally spanned 12 months over two fiscal years (2008 and 2009) with a total one-time compensation package in the amount of $75,000. The prorated funding allocation for fiscal year 2008 was $37,500 and covered the period of October 1, 2007 to March 31, 2008. The funding allocation for 2009 was increased to $75,000 (2008 - $37,500) to cover the entire fiscal year to March 31, 2009. During the year, $71,651 of expenses were incurred (2008 - $30,702).

15. Ontario Wait-Time Strategy

The Ministry of Health and Long-Term Care provided $70,000 in one-time funding in the 2008 fiscal year to support wait list management activities within the LHIN. This funding supports Ontario's Wait-Time Strategy, which includes the development of a comprehensive system to monitor wait times and help ensure that Ontarians receive timely and appropriate access to five key services. This funding was discontinued for 2009 and there were no expenses incurred (2008 - $70,000).

16. Ontario Diabetes Strategy

The LHIN entered into a partnership agreement with the Ministry of Health and Long-Term Care to implement the Ontario Diabetes Strategy (the "ODS"). The ODS spans two fiscal years (2008 and 2009) with a total one-time compensation package in the amount of $474,700. The funding allocation for fiscal year 2009 was $224,700. During the year, $152,351 of expenses were incurred.

17. ER/ALC Performance Lead

The Ministry of Health and Long-Term Care provided one-time funding in the amount of $33,300 to support the compensation of the LHIN ER/ALC Performance Lead for the period of December 1, 2008 to March 31, 2009. During the year, no expenses were incurred.

18. 70% Full-Time Nursing LHIN Engagement Initiative

The Ministry of Health and Long-Term Care provided one-time funding in the amount of $42,750 for the development of a nursing health human resource planning strategy. During the year, $36,333 of expenses were incurred.

19. Aboriginal Health Transition

The Ministry of Health and Long-Term Care approved a one-time funding grant of $438,125 over two fiscal years (2009 and 2010). The funding allocation for fiscal year 2009 was $165,625. This funding is in support of two Aboriginal Health Transition Fund Adaptation Projects that were submitted by the LHIN to the Ministry. The projects include the development of a Mental Health and Addictions Strategy and an Environmental Scan of Aboriginal Health Services and Programs. During the year, no expenses were incurred.

20. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 22 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2009 was $214,987 (2008 - $170,391) for current service costs and is included as an expense in the Statement of Financial Activities. The last actuarial valuation was completed for the plan in December 31, 2008. At this time, the plan was under funded.

21. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act.*

22. Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1, 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and therefore no additional disclosure is required.

23. Comparative figures

Certain of the prior year's comparative amounts have been reclassified to conform with the presentation adopted by the current year.

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ISSN 1920-3497

Ontario
Local Health Integration Network